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Healing a Vulnerable Self: Exploring Return to Work for Women With Mental Health Problems

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Abstract

Mental health problems (MHPs) such as stress and depression are among the leading causes of work disability. In this article we explore how women with MHPs experience sickness absence and subsequent return to work. We conducted 16 semistructured interviews and employed constructivist grounded theory for the analysis. We found that whereas sickness absence constituted a major threat to positive self-images, the experience had potential as a personal growth experience: Although some women felt handicapped, others became stronger and more self-confident. The core of the experience was not the return to work but a process of healing a vulnerable self—the ability both to refocus attention from symptoms to other life goals and to maintain or reconstruct a positive self-image. Supportive health care and acknowledgment from others facilitated the healing process.

Keywords

grounded theory; health and well-being; health care; illness and disease experiences; mental health and illness; self; women's health; workplace

Common mental health problems (MHPs), such as stress, depression, and anxiety, have a considerably negative impact on quality of life, social functioning, and work ability. In Denmark, disability pensions related to MHPs rose dramatically between 2002 and 2006, with the highest increases in stress-related disorders (102%), anxiety (69%), and depressive disorders (63%). Today MHPs account for 51% of all disability pensions and are now the leading cause of work disability in Denmark and many other European countries (Brown et al., 2009; Decision of the National Social Appeals Department, Denmark, 2010; Hensing, Andersson, & Brage, 2006; Nystuen, Hagen, & Herrin, 2001).

Disability and subsequent sickness absence often have profoundly negative implications for work life by jeopardizing social relationships at work, reducing career opportunities, and increasing the risk of work loss (Sieurin, Josephson, & Vingard, 2009; Tarasuk & Eakin, 1995). Earlier, Ockander and Timpka (2003) compared sickness absence and unemployment, arguing that both include a work loss that constitutes a break from normal everyday life and threatens life plans. Similarly, Svensson, Mussener, and Alexanderson (2006) suggested that because identity in contemporary Western culture is

closely linked to work life, sickness absence is detrimental to both self-esteem and feelings of being in control.

Return to work (RTW) is a complex social process (Loisel et al., 2001), and during the last decade policy makers in many European countries, especially the Nordic welfare states, have introduced a range of policies for facilitating RTW (Johansen et al., 2008). In Denmark, where this research took place, employees on long-term sickness absence for MHPs are less likely to return to the same employer—possibly because of the stigma attached to MHPs. However, knowledge about RTW for employees with MHPs remains scarce, because most researchers focus on musculoskeletal problems (Høgelund, Filges, & Jensen, 2003). Several researchers have proposed that a deeper understanding of different stakeholders'

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perspectives on RTW will improve RTW research and practices. Yet these perspectives usually go beyond the measures typically used in RTW research (Young et al., 2005). Therefore, Rauscher and Greenfield (2009) have suggested that qualitative methods are particularly suitable for exploring social and behavioral aspects of health and disability at a deeper level, and that qualitative methods will facilitate a more nuanced understanding of RTW.

In this study, we explored how Danish women on sickness absence for MHPs constructed meaning from their transitions in and out of work. Whereas most qualitative studies focus on long-term sick leave, we included women with both short- and long-term sickness absence and women who had successfully returned to work, allowing us to explore more favorable RTW trajectories that will give a more comprehensive picture of the process. Moreover, we focused specifically on women, because they are more likely to suffer from depressive and anxiety disorders, to become sicklisted, and to become permanently disabled (Statistics Denmark, 2011). This gender gap might be attributable to differences in stress exposures, stress responses, or both (Nolen-Hoeksema, 2001). Women's lack of social power is one of the driving factors underlying the increased risk of stressful life events. Although most women in Denmark are gainfully employed (72%), the Danish labor market is characterized by both horizontal and vertical gender segregation. Women work predominantly in the public sector and have part-time jobs; they are less likely to be self-employed or top managers (Statistics Denmark). Additionally, women not only are more likely to experience trauma (e.g., sexual abuse), poverty, lack of respect, and constrained choices, but are also more vulnerable to these stressors because of their biological responses, self-concepts, and coping styles (Nolen-Hoeksema).

Theoretical Framework

Our research was based on the theory of symbolic interactionism, which according to Blumer (1969) essentially rests on three premises: (a) human beings act toward things based on the meaning those things have for them; (b) meanings derive from, or arise out of, social interactions; and (c) people use an interpretive process to deal with the things they encounter. From this perspective, the consequences of sickness absence and RTW depend on the intentions, interpretations, and interactions of the individual. Inspired by Ezzy (1993), we suggest that conceptualizing work as good and sickness absence as bad might be too simplistic for explaining employees' motivation for and understanding of RTW. Employment is related to health in complex ways, posing both risks and benefits. Although work loss and unemployment are strongly related to reduced mental health, so is a poor working

environment (Broom et al., 2006). Drawing on the perspectives of social identity theory and symbolic interactionism, Ezzy argued that the negative effects of work loss can be understood as a disruption of personal strategies for maintaining consistent and positive self-images.

Social identity theory suggests that to maintain desired roles and positive self-concepts, people set up life plans through the establishment of routines and interactions with others. These routines and interactions provide stable sources of legitimacy for identities. Major disruptions to these life plans, however, threaten the basis for legitimizing valued social roles and might therefore lower self-esteem and raise anxiety. Thus, if going to work is an integral part of maintaining a positive view of the self, and if an individual is not able to find a satisfactory alternative identity, work loss will result in lowered mental health. In contrast, if employment plays only a minor role in enabling the person to maintain a meaningful life, the loss of work will be much less severe (Ezzy, 1993).

Legislative Context

The Danish public sickness benefit program covers wage earners, the self-employed, and the unemployed for a general maximum of 52 weeks, with no distinction between work-related and non-work-related sick leave. Employers in Denmark have little responsibility for financing social benefit programs and few obligations for reintegrating disabled employees (Johansen et al., 2008). The Danish municipalities, which are administrative entities resembling counties in the United States, pay sickness-absence benefits for absences longer than 3 weeks. Furthermore, social insurance officers from the municipal job centers are responsible for conducting monthly follow-up evaluations and developing reintegration plans for people on sick leave. These officers also have the right to decide whether an individual is entitled to sickness benefits. Although the principles underlying entitlement to sickness benefits are characterized by a holistic view on work disability, the decision process might also rely on information from general practitioners or other medical specialists (Johansen et al.).

Methods

Recruitment Procedures

We recruited the participants from the research project CORSA (Common Mental Disorders, Return to Work, and Long-Term Sickness Absence). The participants in the CORSA project consisted of employees who applied for sickness-absence benefits from a municipal job center in Denmark. They had applied on the grounds of self-reported MHPs or difficult life events, such as

bullying or bereavement, from May 2007 through December 2007. A total of 721 employees (31% men, 69% women) fulfilled the inclusion criteria and therefore received a baseline questionnaire ($n = 298$; response rate = 41%) and a 6-month follow up ($n = 236$; response rate = 71%). Next, to select a heterogeneous sample of participants for factors such as age, educational background, and self-reported reason for and duration of sickness absence, we used the data from the baseline and follow-up questionnaires. We invited only women to participate, because they make up the vast majority of sick-listed employees with MHPs. Finally, the first author invited 24 possible participants by telephone; eight women declined the invitation, leaving a final sample of 16 participants.

We have presented a more detailed description of the enrollment procedures and the results of a nonresponse analysis elsewhere (Nielsen et al., 2010). We conducted the nonresponse analysis to compare the characteristics of the responders and the nonresponders to the questionnaires. We found that the nonresponders were more likely to be men, to be manual or service workers, and to give depression as their reason for absence. However, responders and nonresponders were comparable for age, RTW status, and their prevalence of prior sickness absence (Nielsen et al.).

Data Collection

To explore the sickness absence and RTW experience, we constructed a semistructured, open-ended-question interview guide covering key events and interactions with health care professionals, colleagues, supervisors, friends, family, and social insurance officers. Although we used these questions as a tool for guiding the overall interview, we kept the interviews as open as possible, thereby allowing unanticipated statements, stories, and personal experiences to emerge (Charmaz, 2006).

The interviews, averaging from 1 to 1.5 hours in length, took place at the participants' homes, workplaces, or the research center. We conducted 16 audiotaped interviews from June 2008 through December 2008. The first and third authors conducted the first four interviews together; thereafter, the first author conducted the remaining twelve interviews. The participation of the two interviewers in no way appeared to affect the interviews, most likely because of a clear division of roles: The first author acted as the principal interviewer, and the third author acted as a silent observer. We carefully explained these roles to each participant before the interview. The advantage of having two observers was that we could discuss and evaluate the interview retrospectively to improve quality and depth of data. To create a safe and trusting atmosphere, and to avoid any misunderstanding that the

interview was a therapeutic consultation, we explained to the participants that we were not affiliated with the job center, and that we had neither medical nor psychotherapeutic backgrounds. Given the sensitivity of the topic, we conducted individual face-to-face interviews with the assurance of anonymity.

Analysis

To develop a conceptual theory explaining the RTW process, we employed constructivist grounded theory inspired by symbolic interactionism (Charmaz, 2006). The grounded theory method is a set of flexible tools for guiding both data collection and analysis focused on creating conceptual frameworks through inductive analysis. Constructivist grounded theory, as outlined by Charmaz, addresses how individuals, as well as researchers, construct the realities in which they live. From the constructivist perspective, data and analysis do not simply emerge but are created, so that research findings therefore represent an interpretative portrait of the world. Moreover, this inductive approach implies that analytic categories should be grounded in the data as opposed to preconceived theoretical concepts (Corbin & Strauss, 2008). To keep the focus on emergent themes and concepts in the data, Charmaz cautioned against conducting thorough literature reviews during the initial research phases.

Two authors independently coded the first four interviews, subsequently discussing and elaborating on concepts and themes and their properties, to validate findings and enrich the analysis by incorporating different viewpoints and interpretations of the data. Next, the first author continued the data collecting and memo writing alone. To help organize the data, we used Corbin and Strauss's (2008) Paradigm Model, a perspective that enables the researcher to analyze process and context in terms of actions, interactions, emotions, consequences, and enabling factors. The Model helps to enrich the analysis by allowing the researcher to more clearly understand the circumstances surrounding the events. However, as the Model constitutes a set of questions, not a set of directives, the researcher does not code for conditions *per se*. According to Corbin and Strauss, the identification and selection of the core category is a pivotal step for theory development. This category represents the main theme and conveys what the research covers and means. Following Corbin and Strauss, we selected the core category for its explanatory power; that is, a category to which all other concepts and subconcepts could be linked.

Finally, we developed an analytical story line based on this category and its related subconcepts. We checked for gaps in the logic by rereading all the interviews, looking for negative cases, cross-checking with similar concepts from the literature, and discussing the analysis with

colleagues. The story line helped us to integrate themes and concepts into a coherent conceptual explanation of the RTW process based on empirical findings. Following Charmaz (2006), we conducted the literature review after the analysis; only after we had developed our emergent themes and concepts did we begin comparing them with previous concepts from the literature.

Ethical Considerations

We notified and registered this study with the Danish Data Protection Agency. According to Danish law, only research using biological material needs approval from the Danish National Committee on Biomedical Research Ethics. Although we were unable to offer the participants any treatment, all participants had contact with their general practitioners, and the majority had contact with a psychologist. In one instance, we referred a participant to a free help line. Considering the possible psychological impact of the interviews, we took the following precautions: Using the Major Depression Inventory—a 10-item self-rating scale for symptom characteristics for depression in accordance with the *Diagnostic and Statistical Manual of Mental Disorders—IV* (American Psychiatric Association, 2000)—we did not contact women who met the criteria for a major depression. Moreover, we did not contact those who stated in the 6-month follow-up questionnaire that their health had worsened. The one disadvantage of this approach was that the women we did not contact were not able to share their experiences.

Findings

A total of 16 participants from various occupations—including manual work, health care, social work, education, administration, sales, service, and technical work—participated in the interviews. The duration of their sickness absences ranged from about 2 to 15 months (mean duration was about 5 months). At the time of the interview, 11 participants had returned to work full time, 2 returned part time, 1 returned to school, 1 was unemployed, and 1 remained on sick leave. Among those women who returned to work, 8 were still employed by the same employer.

The women had in common the experience of a variety of emotional, cognitive, and somatic symptoms, such as sleep disturbances, lack of concentration, headaches, dizziness, sadness, and anxiety. Emotional loss of control, such as crying for no particular reason, led to fears of going insane, and some reported that they did not recognize themselves: “I felt like I was standing next to myself looking at this wrong version of me.” Whereas their symptoms varied in duration and intensity, they all

experienced an emotional crisis or breakdown, characterized by feelings of being powerless, overwhelmed, and exhausted. Furthermore, all of the women attributed these symptoms to an MHP, such as stress, depression, anxiety, or burnout, and reported this MHP as their official reason for absence. This analysis begins at the time of the sickness reporting. In the following section we present both the core problem and the findings resulting from the analytical story line.

Central Problem

The analytical story line revealed that sickness absence for an MHP constituted a major threat to self-esteem and a positive self-image. Moreover, the women suffered from the burden of a double identity crisis related to interpretations about mental illness as a reflection of a vulnerable self and a loss of valued social roles. Karp (1996) proposed that depression is a unique disorder, because it is a condition of the self that emanates from and reflects back on a self that is somehow inadequate or damaged. Likewise, we found that the women’s experiencing the self as vulnerable stemmed from their interpretations of MHPs as originating from a self that was somehow fragile or vulnerable. In general, the women believed that an overload of their work life, their personal life, and traumatic life events caused their distress, and that certain attributes of the self made them particularly vulnerable to these stressors. These attributes, or personality traits—such as being too contentious or being a perfectionist—appeared related to a gender understanding of the roles they had been raised to fulfill both as women and as good workers.

Researchers have consistently shown that interpersonal orientation differs in men’s and women’s self-concepts; even in childhood, girls appear more interpersonally oriented than boys. When women subordinate their own need and desires, they become excessively dependent on the good graces of others, thereby possibly increasing their risk of depression when conflicts arise in relationships (Nolen-Hoeksema, 2001). We also found that such traits prohibited the women from taking care of their own needs and well-being:

I have requested too much of myself and somewhere down the line that is also the problem. I always want to make sure that everybody else is fine and then forget about myself, and in the end I have to pay the price.

Not being able to fulfill valued roles reduced self-esteem and induced feelings of guilt about becoming a burden both to colleagues, who had to take over their duties, and to the social welfare system:

While I was off sick, I constantly felt guilty about being at home and not working, and I did not feel comfortable about it. I want to take care of myself. I don't want society to take care of me.

This finding concurs with those of other researchers who have shown that sickness absence has negative consequences in terms of guilt, shame, and isolation (O'Donnell, MacIntosh, & Wuest, 2010; Tarasuk & Eakin, 1995; Verdonk, de Rijk, Klinge, & de Vries, 2008).

The Healing Process

Although sickness absence with MHPs negatively affected self-esteem, the core of the women's experiences was not absence from or resumption of work per se. Their experiences basically focused on "getting better," which we conceptualized as "healing." To be healed, in this context, meant to live an unrestricted life; that is, having the ability to refocus attention from symptoms to other life goals and, equally important, to either maintain or reconstruct a positive self-image. Therefore, the healing process constituted more than merely attenuation in symptoms and increased work functioning; on a more fundamental level, it was a process of healing a vulnerable self. In the following sections we explain this process in depth and situate the healing process in the context of sickness absence and RTW.

Discovering true self. To take action toward healing, the women needed an understanding of their condition, including its causes, prognosis, and consequences. In general, they interpreted symptoms as expressions of malfunctioning that, if ignored, could lead to physical illness and even life-threatening conditions, and stressed the importance of conscientiously and promptly reacting to personal limitations and bodily and emotional symptoms. For some, this learning experience came with a high price and painful lessons.

Each woman ventured into a discovery of her true self to better understand "who I am" and "what I need to live a satisfactory life." This discovery involved reflections over past, present, and future selves as a way of regaining a sense of a strong and capable self: "For me it was a wake-up call, because my life wasn't going in the right direction. So I have gained a lot, and I am really grateful about what I have learned." What the women had in common, however, was the belief that to be healed, one had to act in accordance with one's "true self" and break old habits: "This is my time, because I will not go through this again. So now my goals are much more selfish and more about what I like and what makes my life richer."

Getting professional help. The majority of the women had visited psychologists, therapists, or coaches. These professionals, especially the psychologists and occasionally the

general practitioners, acted as important mediators of the discovery of the true self. Furthermore, both health care professionals and acquaintances also suffering from MHPs provided the women with important reference points for the severity and duration of their condition, and the professional feedback on their recovery gave the women a sense of accomplishment and direction. Finally, hearing about or talking to others with similar experiences substantiated the feeling of "not being the only one this happened to," thereby framing MHPs as a societal problem, not merely a personal one.

Emotional support and a trusting relationship were preconditions for successful treatment, and the women highlighted the importance of being taken seriously:

When I visited my former physician and said, "I think I am stressed out." Then she laughed and said, "Yes, aren't we all." She never took it seriously, so it was nice to talk to someone who did [the new physician].

The women also emphasized the importance of sharing the same treatment goals and not feeling pressured to return to work:

She [the physician] kept telling me that I would be ready soon, and I am sure she meant well. But when you already feel guilty about being on sick leave, then it feels like pressure, because the doctor says so—and the doctor is an authority figure.

Consistent with findings from O'Donnell et al. (2010), we found that the health care professionals played a key role in legitimizing the condition as an illness that needed attention and care—thereby validating sickness absence. Thoits (1985) suggested that patients seeking health care usually get what they want—namely, social support—and that therapists usually help their clients feel better by validating negative emotions that violate social norms. Although prolonged and recurrent negative emotions often trigger negative reactions from others, therapists are in the business of helping their clients to understand these feelings, thereby aiding in restoring consistency between these feelings and social norms.

Creating time and space for healing. During the first weeks of absence, the women found themselves preoccupied with resting and restoring sleep to "calm down." They felt unable to think rationally, make important decisions, or perform everyday tasks such as shopping or talking to other people:

Suddenly, I did not know how to cook, and that is a really basic task. It was almost like learning to ride a bike all over again, and that it is why it was

nice to be off sick for some time, because everything happened so slowly.

To manage negative emotions and solve problems, the women gradually engaged in different active strategies, such as doing physical exercises, journal writing, meditating, and calling friends. They slowly began returning to something that resembled a normal day. Taking sick leave therefore primarily created time and space for healing, and getting away from stressors at work became an appreciated break from everyday hassles and a valued opportunity for reconsidering work life in particular and life in general.

We are not the first to suggest that sickness absence is an intentional behavior. Kristensen (1991) argued that sickness absence can be viewed as an active coping strategy that is strongly affected by working conditions and perceived health. O'Donnell et al. (2010) reported that women experiencing workplace bullying reported sick to "gain space," which was the process of physically separating from the work place as a way of recovering.

Framing sickness absence. Sickness absence changed the normal routines and interactions with friends, families, colleagues, and supervisors. By reporting sick, these women made their health problems visible to others, and their sickness absence with MHPs implicitly signaled to the workplace that something was wrong and that someone was responsible for the situation. From the women's standpoint, the supervisors tended to interpret MHPs as a personal attribute of weakness and inability to manage work, while downplaying the possibility of working conditions being a cause of mental illness. Consequently, the women risked having their managers and colleagues label them as weak individuals who could not manage their workloads.

Sickness absence therefore became a starting point for negotiations, not only about working conditions and RTW but also about blame and responsibility. These negotiations had profound implications for the healing process, both impeding the constructing of the self as strong and capable and diminishing self-esteem. To avoid being labeled, the women felt compelled to legitimize their health problems and sick leave. We identified two modes of framing sickness absence, both of which served as moral arguments for reporting sick and thus not fulfilling the "successful worker" role: sickness absence as a "last resort," and sickness absence as a "preventive act."

In accordance with Verdonk et al. (2008), we found that, for some women, reporting sick was "the last resort," when all other options—for example, seeking health care or talking to the supervisor about reducing the workload—had proven unsuccessful. These women interpreted sickness absence as a personal coping failure: "Your self-confidence is broken. And it is a personal defeat that

I was not able to manage." At the same time, their reluctance to report sick was also a testimony of the severity of their health problems and high work ethics:

You hear all the time [in the media] that it is the responsible employees that get run down—as if it is praise! For me, it is a failure, and you cannot explain it away. You feel like a failure, and it is taboo to go out and tell everyone that this happened to me.

In contrast, others presented sick leave as a preventive act—an active way of coping with a critical situation that potentially could have led to a major breakdown. Framing sickness absence within a preventive discourse promoted the construction of a more proactive self-image as opposed to being helpless and victimized:

If you feel a little burned out, then talk to your doctor, and if you have to report sick for a couple of weeks—then do it! Do yourself a service and take care of yourself. Nobody else will do it for you! I really want to stress the importance of being attentive to symptoms and signals of danger—otherwise you might get physically ill.

The RTW dilemma. Working conditions played a considerable role in the women's understanding of the etiology of the condition, and their experience therefore prompted them to reappraise work life. At the time of interview, none of the women expressed any intention of leaving the labor market by, for example, seeking a disability pension. Thus, the women's main concern was to decide whether to return to their old workplace or find a new one, and when and under what conditions to resume work.

Their outlook on a future work life was affected by their perceived work ability, possibilities on the labor market, and wishes for a future work life. Consequently, both individual preferences (e.g., salary and supportive colleagues) and factors at the structural level (e.g., age and educational background) influenced their decisions. Some of the women changed workplaces out of necessity, realizing that "things would not change at work" (e.g., because of conflicts with management or colleagues), and some were fired. Finally, others reported that their job was not consistent with their true self, a realization more common among the younger women (>50 years), who thought that it was "not too late to change careers."

At the time of the interviews, most of the women were back at work either full time or on reduced working hours. The majority reported that they had returned before full recovery and struggled to keep pace at work. At the end of the workday, they were exhausted, with little

energy for pursuing leisure-time activities. While struggling at work, the women thought that their colleagues and supervisors interpreted RTW as a “return to a normal everyday life”:

From Day One they [supervisor and colleagues] expect that you can manage exactly the same as before. So you have to put your foot down, and that is really difficult. But you just have to practice saying no. Otherwise, you’ll become as stressed out as before—or at least there is a big risk that you will.

Becoming handicapped or stronger. Despite the potential healing process, RTW constituted a dilemma, because the women feared relapses, especially when returning to working conditions that they thought were detrimental to their health. Moreover, even though sickness absence negatively affected their self-esteem, resuming work did not automatically lead to an improved self-image or self-esteem. Whereas most of the women had successfully resumed work, their stories and retrospective self-evaluations revealed that the experience had had a profound impact on their well-being and self-image.

For some women the sickness absence marked the beginning of a continuous marginalization process, with irreversible consequences for their work ability and social functioning. The result was a damaged self-image, described here as becoming “handicapped”:

For the rest of my life, I have to take care of myself. I hope I will be able to work full time, and I hope that I will be able to live a normal life, but I know I have to take care of myself for the rest of my life. So you might say that I have become handicapped in some way. That has been a difficult acknowledgment, because it changed my perception about myself as a wife and a stepmom and all sort of things.

For such women, feeling “handicapped” was related to experiencing prolonged emotional distress and reduced functioning and work ability. The condition became a central part of their daily lives, and restricted their performance of daily activities and fulfillment of valued social roles in their family and at work. In contrast, other women reported that they became stronger and more self-confident. The experience had an almost empowering aspect—resulting in a stronger and more confident self-image—through a better understanding of who they were in the past, who they were in the present, and what their needs were. By changing behavioral patterns that were detrimental to their health and well-being, they felt stronger and better able to manage work. For these women, the loss of work ability was just a phase, not an irreversible process:

I actually believe that I am more capable . . . because I believe more in myself, and I believe that I can be an asset for a company. Back then it was more about doing what everybody else said. But, absolutely, I am more capable of setting limits, so I see myself as stronger and more capable now.

Discussion

In this article, we have presented the concept of the vulnerable self, which we identified as the core problem. Basically, we found that women on sickness absence with an MHP suffer from the burden of a double identity crisis, stemming not only from their interpretations of MHPs as a reflection of a vulnerable self but also from the loss of valued social roles at work and at home. The idea that illness experiences are characterized by critical turning points in identity has also been widely investigated in research on chronic illness. For example, Bury (1991) and Charmaz (1983) have argued that chronic illness represents an event that breaks with the normal biography—the stable pattern that constitutes everyday life—and that this event disrupts the person’s ongoing life, carrying the potential to alter his or her sense of self and introduce an experience of a loss of self. However, Gannik (1999) criticized their research for taking its point of departure in chronic illness, thereby leading to a problematic categorization of illness as an ongoing downward spiral and an artificial classification of illness as either chronic or nonchronic.

We do not suggest that the women in this study experienced a permanent loss of self, but rather that they experienced a crisis or disruption that might or might not have been reversible. We also found that this crisis could have potential empowering aspects and that some women felt they became stronger and more capable than before their absence. Svensson et al. (2006) suggested that self-esteem and empowerment are pivotal concepts for sickness absence and RTW research, and that the most important task for rehabilitation professionals is to empower employees on sick leave to view RTW as a realistic and obtainable goal. Given our findings, we suggest that empowerment and self-esteem should be considered not only as a means by which people can resume work but also as an RTW outcome in its own right.

The differences in individual story lines appeared to relate more to the women’s perceived health status than to their current RTW status, because most participants had already resumed work. However, because we only included women, we do not know whether the same process holds true for men. Previous research on men’s and women’s return-to-work patterns has produced inconclusive findings for sickness absence with mental health problems. Although some studies have shown that women

have a higher risk for prolonged absence, others have shown the opposite pattern (Lagerveld et al., 2010).

In Denmark, women experience more stressors and have a higher risk of becoming permanently disabled from work (Labriola et al., 2011). Labriola et al. found that differences in the psychosocial work environment (e.g., emotional demands, rewards at work, management quality, and role conflicts) explain about 30% of Danish women's increased sickness absence (compared to the level of sickness absence in men). Variations in the women's personal and occupational background, however, did not seem to greatly influence the healing process. Findings were consistent across different ages and occupational and educational groups, with the exception of the women's outlook on their future work life: Younger women tended to be more positive about seeking new employment than older women.

To our knowledge, we are the first to report positive outcomes of sickness absence, possibly as a result of our selection strategy; that is, most of the women were already back at work. Most qualitative studies have been focused on long-term sick leave, a focus that has contributed to our understanding of sickness absence as a process of marginalization from the labor market. However, by focusing on more favorable RTW trajectories, we have presented a more nuanced understanding of what constitutes a successful RTW. Within occupational rehabilitation literature, work resumption is usually the main outcome of interest, and few authors have contested or questioned the current reductionist notion of what constitutes a successful RTW. However, findings from our study show that merely focusing on employment status does not fully capture the lived experience.

Next, we explained the process in which women with MHPs engage to regain a sense of self as strong and capable, and we conceptualized this process as healing a vulnerable self. This process resembles findings from Parsons, Eakin, Bell, Franche, and Davis (2008), who reconceptualized and expanded on the meaning of "work" in the RTW process. They found that people on sickness absence related to cancer engage in different kinds of activities or types of "work," including "identity work," which they defined as active engagement and agency in coming to terms with the profound changes in self-perceptions that the illness created.

Findings in this study point to important factors that might facilitate or hinder this healing process. These factors include quality health care and negative workplace attitudes toward employees with MHPs. We found that social interactions between employers and coworkers were crucial for RTW. One possible explanation for this finding is that the employer acts as a gatekeeper to work accommodations and that whether the worker feels comfortable about returning to work at a reduced capacity

crucially depends on the work atmosphere. Furthermore, an unwelcoming or distrustful atmosphere might also contribute to low self-esteem, thereby reducing the mental well-being of employees returning to work.

We also found that psychologists, in addition to employers, played an important role as facilitators of the discovery of the true self and the healing process. In an article on sickness absence among highly educated Dutch women, Verdonk et al. (2008) likewise found that many of the women in their study turned to psychologists or psychological counselors. Verdonk et al. were critical of this practice, suggesting that the psychological counseling reinforced an individualization of MHPs by encouraging the women to look at their own personalities. Consequently, they argued, the treatment did not adequately prepare the women for RTW, because the counseling did not focus on working conditions.

We agree that reducing MHPs to a question of personality involves a significant risk of stigmatization and of blaming the victim. However, most of the women in the Dutch study were still on sickness absence, whereas the majority of the participants in our study were back at work, thereby possibly explaining our more positive findings. Whereas several studies have examined the relationship between the absentee and different types of professionals in the RTW process (Franche, Baril, Shaw, Nicholas, & Loisel, 2005; Ostlund, Borg, Wide, Hensing, & Alexanderson, 2003; Shaw, Hong, Pransky, & Loisel, 2008; Young et al., 2005), none focused specifically on psychological counselors. Future research on RTW in employees with MHPs should take this particular group of health care professionals into account, because these professionals might play an important role for both sickness absence and RTW behaviors.

Finally, we showed that RTW constituted a dilemma, because the women feared having relapses and because returning to work did not automatically result in improved self-esteem. Young et al. (2005) have suggested that RTW would financially benefit most employees in the long run and might even increase quality of life by helping the disabled worker maintain a desired place in society. In this article, we have suggested that the relationship between health and well-being and RTW is much more complex.

Separating the negative effects of sickness absence from the negative effects of MHPs is difficult. Low self-esteem is one of the accompanying symptoms in depressive disorders, and the display of emotional distress can trigger negative social reactions, keeping the already ill person from reaping important social rewards, such as self-esteem and approval from others (Thoits, 1985). Thus low self-esteem might not only result from taking sick leave but is also likely to be part of and a result of the condition itself. Likewise, returning to work can also be detrimental to mental health and well-being for employees who, for

example, experience bullying or stigmatization at work. Therefore, in line with recommendations from Parsons et al. (2008), we caution against perceiving employment status as the only parameter for a successful RTW.

Strengths and Limitations

The limitations of this study were related to the number of interviews: Because we interviewed each participant only once, we were not able to investigate whether their perceptions of self and self-esteem changed over time. Despite this limitation, we believe that we have achieved saturation for the following three reasons: Saturation depends on numerous factors, including the scope and the nature of the study and the quality of the data (Morse, 2000). We first carefully selected the participants by using in-depth background data from questionnaires, thereby ensuring that they had extensive and diverse experiences with sickness absence with an MHP. Such detailed participant information is usually not available. Second, the subject of the study was clear, because we were eliciting specific events and interactions. Third, we restricted our scope to sickness absence and RTW, and therefore to a limited period in the participants' lives. Nonetheless, had we included multiple stakeholders, such as health care professionals, employers, and colleagues, we might have gained a more comprehensive picture of the RTW process as seen from different viewpoints.

A major strength of this study was the crosschecking of the analysis between the two interviewers and the participation of the two interviewers in the first four interviews, both of which actions improved the quality of the data collection. Unfortunately, we were unable to continue this strategy throughout the entire research project, because the second researcher left the research project. Finally, the use of constructivist grounded theory was yet another strength of this article. Grounded theory is particularly useful for studying processes, providing the researcher with analytical tools for rendering a procedural rather than a static analysis (Charmaz, 2006). By focusing on the concept and themes grounded in the data, we have presented a different perspective on RTW. The combination of this perspective and the selection strategy contributed new insights into more favorable RTW trajectories.

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